with recommendations given by a committee from the Richmond Area Community Council and approved by the Richmond Academy of Medicine.

The present program of home care has been developed in close association with the Medical College of Virginia. Its medical director is a professor of clinical medicine at the college. He is assisted by two other supervising physicians on the Medical College faculty who instruct the students and assume responsibility for patient-care. Second-year resident physicians in training at the school devote approximately two months to the home care program, and senior students serve for slightly shorter periods. The students are assigned cases—providing an extremely valuable supplement to their ward experience. Physicians are assisted in working out home care plans by the chief public health social worker and her staff; and nursing service is provided by the newly organized Community Nursing Service, formed from a merger of the Instructing Visiting Nurses Association and the Nursing Division of the City Health Department. Housekeeper service is available through the Family Service Society.

In spite of the many new and expanding features of this medical care program, the cost for operation of the Medical Aid Bureau has not increased appreciably during the five years of the present program, since an economy has been effected by reduction in length of hospital stay per patient and in many other ways.

This seems an admirable example of imaginative, cooperative community effort which should markedly improve the quality of medical care provided for lower income groups and should be of substantial value in broadening the education given to medical students.

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1. Coordinated Medical Care. Virginia Health Bull. Vol. 6, Series 2, No. 4 (Aug.), 1953.

Health Education in the Philippines

✠ A recent report [1] of the Expert Committee on Environmental Sanitation of the World Health Organization tells a story which admirably illustrates the basic principles of community health education, in the most modern sense of the term.

The scene was a small village in the Philippines where no up-to-date sanitary facilities existed, in spite of a formal regulation on the statute books requiring adequate toilet facilities for every dwelling. Vigorous attempts to enforce the law induced only an occasional sanitary privy, which was always kept locked, except on the rare visits of the sanitary inspector.

Then a real health educator hit on the right approach. A proposal was made for a routine examination of the stools of children; and this at once struck a responsive chord. The mothers knew that many of their children had intestinal trouble; and when the survey showed that 73 per cent of the children were harboring some sort of intestinal parasite the picture changed. Here was a "felt need"; and the community was ready for better methods of handling intestinal discharges. But before progress could really be accomplished it was necessary to demonstrate a practical and economical method of solution, one endowed with local social prestige and not enforced from without. A native contractor was found who could supply concrete toilet bowls at a cost of $4.50 each (instead of $40 for the cheapest imported commercial product). Such a toilet bowl was first installed in one of the schools and then in the homes of the teachers. Today, out of 251 families in the district, only eight remain without such sanitary provision.

Could there be a neater example of the basic principles of modern health education, which involves "leading out" from the needs and habits of the population concerned, rather than indoctrination from above?

1. Tiglao, Teodora V. Health Education Aspects of a Sanitation Programme in a Philippine Rural Area. WHO Expert Committee on Environmental Sanitation. WHO/Env. San./49, May 11, 1953.

The Role of Epidemiology in the Control of Tuberculosis

✠ Dean Thomas Parran of the School of Public Health in Pittsburgh has recently given us an admirable up-to-date review [1] of our progress in the control of tuberculosis, the study of which we strongly recommend to our readers.

Dr. Parran makes an especially important point when he emphasizes the desirability of routine "sole leather" epidemiology in the control of this disease. A half a century ago, the distribution of the tubercle bacillus was so universal that epidemiological procedures had little value. Today, the picture is a wholly different one; in many communities cases of tuberculosis (and of syphilis) are so infrequent that the disease exists in relatively small household, neighborhood, or occupational epidemics. It is important, in such areas, to investigate the contacts of every new case with the same care as would be given to a case of smallpox or diphtheria.

That the present situation is far from such an ideal is indicated in a study [2] by Robert J. Anderson, Herbert I. Sauer, and Roger L. Robertson. They report an analysis of tuberculosis case registry statistics for areas including about half the population of the United States. The analysis indicated an average of 339 known significant tuberculosis cases and 159 known active cases per 100,000 population. In 43 per cent of the cases living at home, the sputum status was unknown to the health departments reporting.

1. Parran, Thomas. Tuberculosis: A Time for Decision. Pub. Health Rep. 68, 10:921 (Oct.), 1953.
2. Anderson, Robert J., Sauer, Herbert I., and Robertson, Roger L. Tuberculosis Cases Known to Health Departments. Ibid. 68, 7:641-646 (July), 1953.